Quality Management Plan - 1915 (c) Waiver

North Carolina Department of Health and Human Services
Division of Mental Health, Developmental Disabilities and Substance Abuse Services

Introduction

The North Carolina public system for mental health, developmental disabilities, and substance abuse services is in the fourth year of a seven-year comprehensive restructuring and reform process that builds on reform legislation passed in 2001. Key components of this reform include:

- Consumer involvement at all levels,
- An emphasis on home and community based services, including CAP-MR/DD waiver design and development to:
  - Address the needs of individuals at the ICF-MR level of care in the community;
  - Provide services and supports that will enable individuals to move from ICF-MR state operated facilities and group homes into the community;
  - Better tailor services to individuals through a person centered approach to planning;
  - Offer service options that will facilitate individuals continuing to live in or return to live in private residences.
- Local accountability,
- Effective services and supports based on evidence-based practices,
- Data-driven and outcomes-focused decision making.

Design of the Quality Management System

Development of a Quality Management (QM) system for the CAP-MR/DD waiver and the system as a whole is one of the fundamental building blocks of Mental Health/Developmental Disabilities/Substance Abuse Services reform in North Carolina. It is the intent of the State MH/DD/SAS Plan that a QM system integrates and analyzes information from multiple sources and functions within the state service system. Quality Management processes must be accountable to all stakeholders and findings must be published, including the assessment of quality improvement activities. The specific objectives related to QM are:

- The Division will develop and execute a comprehensive QM system focusing on continuous quality improvement.
- The QM system will be outcome-based.
- Performance indicators for all levels of the system will be included in the QM process.
- The Division will develop measurement criteria for models of best practice to be included in the QM system.
- The Division will establish competency requirements for all segments of the mental health, developmental disabilities and substance abuse services workforce.
- The Division will manage a comprehensive training and education strategy to support the new QM system.

The redesigned QM system including the CAP-MR/DD waiver, will incorporate the Home and Community-Based Services (HCBS) Quality Framework. The QM Team has identified measures within each of the framework's domains that correspond to the goals of the State Plan and the CAP-MR/DD waiver. **Attachment 1** describes all the measures that DMH/DD/SAS is currently using or plans to use to measure system performance. Some of these measures are currently collected, analyzed, reported and reviewed as part of the LME Performance Contract. Mechanisms for regular collection, analysis and review of data on the other measures are currently being devised.

In addition to these measures designed specifically to support the QM plan, DMH/DD/SAS currently collects a wide range of data on service utilization and cost, consumer outcomes and satisfaction, and special projects. **Attachment 2** summarizes this data, which is available for use in the QM system.

Note that an early product of the work described here will be a State Quality Management Work Plan, detailing how DHHS will meet the QM requirements in the HCBS Draft Waiver application over the course of the 3-year period covered by this application. A key component of the efforts to create a comprehensive QM system is a Real Choice Systems Change Grant for QA/QI in HCBS awarded by CMS in 2003.

While the foundation of the QM system is already in place, the NC MH/DD/SAS is using this grant to complete the development and implementation of the information feedback loops that are critical to a system based on continuous quality improvement. The data and performance measures referenced above will be rolled into a cohesive process where information is used to assure quality and drive system improvement. Toward that end, work under the Systems Change Grant will accomplish the following goals:

- Evaluate the process and outcomes of transitioning consumers from institutional to home and community–based care through data collected in face-to-face interviews with transitioning consumers, using other consumers and family members as interviewers;
- Develop a comprehensive, coordinated system of Quality Improvement (QI) committees among provider agencies, local management entities and the NC Department of Health and Human Services (DHHS);
- Use the transition interview data and QI committees to pilot ways to improve service delivery and consumer outcomes and satisfaction through QI processes;
- Develop a long-term plan for expanding the focus of the QI committees to encompass other populations, services, and processes.

This document describes QA/QI processes that are currently taking place and future QA/QI processes in development are being planned as part of the CMS grant activities. The next section provides an overview of the organizational structure of the system and the responsibilities and activities of the primary entities involved in QM. The section also describes the specific quality assurance activities at the local and State level in regard to the CAP-MR/DD waiver. The remainder of the document is organized around the HCBS Quality Framework domains and the CMS regional review protocol components.

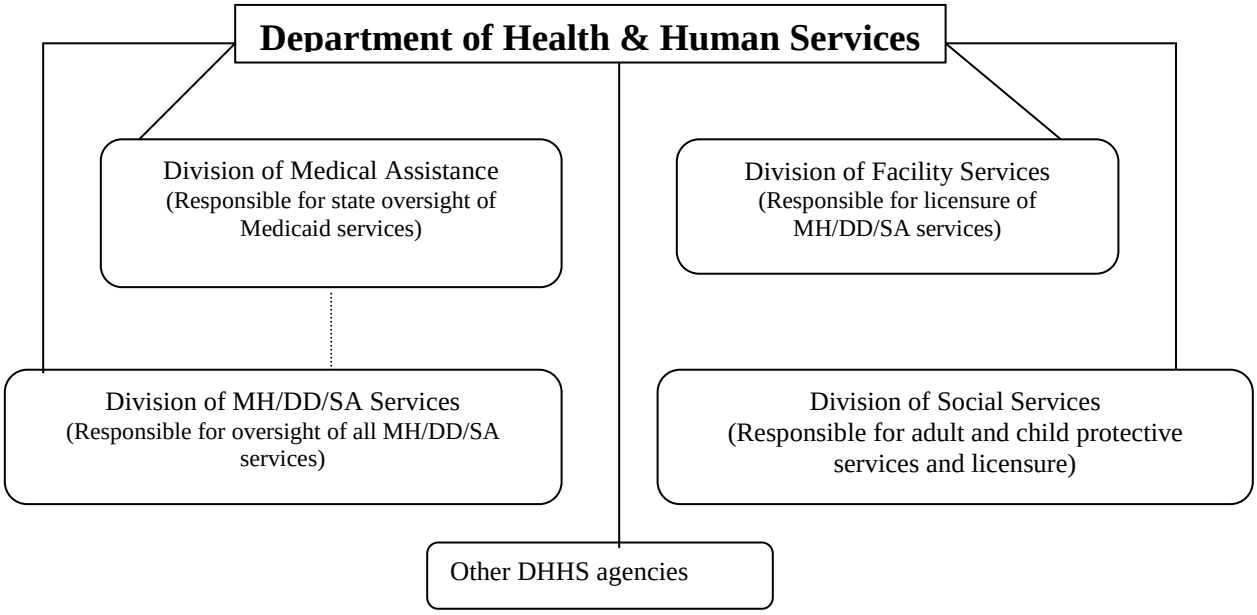
Organizational Context for Quality Management

A Quality Management System is built around a coordinated approach that defines, assigns, and interprets quality related activities across various cooperative entities. The following section describes those entities and their respective roles in the North Carolina system.

State Authority for the Waiver

According to federal and state guidelines, the NC Division of Medical Assistance (DMA) has responsibility for the overall operation of the HCBS waiver. The North Carolina Division of Mental Health/Developmental Disabilities/Substance Abuse Services (DMH/DD/SAS) is the lead agency for overseeing the daily operations of this waiver. The two Divisions cooperate in the operation of the waiver program under a memorandum of understanding that delineates each Division's responsibilities. The Division of Facility Services (DFS), the Division of Social Services (DSS) and the Division of Aging and Adult Services (DOA) have legally mandated responsibilities for licensure of facilities (DFS) and for child (DSS) and adult protective services (DOA.). All of these Divisions are under the authority of the Department of Health and Human Services (DHHS). These relationships are depicted on the chart in Figure 1 below.

Figure 1: NC Department of Health and Human Services



Quality Assurance Responsibilities and Activities within the MH/DD/SAS System

Quality assurance and improvement responsibilities are shared across multiple entities. The system relies on each entity to fill a distinct role while interacting with the other entities. The North Carolina QM system starts with consumers and their families, and builds in a coordinated way to the highest levels of state oversight.

Consumers/Families

Consumers and their families are represented at both the state and local level through Consumer and Family Advisory Committees (CFACs). The CFACs:

- Comment on state and local plans and budgets,
- Help identify under-served populations and gaps in the service array,
- Participate in the monitoring of service development and delivery,
- Advise on the development of additional services and new models of service delivery,
- Participate in quality improvement projects at the provider and LME level.

Local CFACs also participate in a "mystery shopper" evaluation of provider performance and response to service requests.

Providers

Provider agencies are responsible for:

- Licensure and certification,
- Providing Targeted Case Management,
- Development of person-centered plan of care,
- Development of internal quality improvement plans,
- Maintaining internal client rights committees.

Local Management Entities (LME)

The Local Management Entities (LME) are the local lead agencies for the counties they serve, and are responsible for the administration and operation of MR/DD waiver programs in their areas. The functions of the LME include:

- Local business planning to ensure congruence with the State Plan;
- Governance, management and administration;
- Development of a community of qualified providers;
- Operation of a uniform local access system;
- Evaluation and continuous quality improvement;
- Financial management and accountability;
- Management of secure information systems with data on consumers, providers services and finances;

- Service monitoring and oversight, including provider compliance with standards, utilization and performance reviews;
- Technical assistance to providers.

LMEs enter into an annual Performance Contract with DHHS that define the responsibilities of the LME as a waiver lead agency and describe performance standards the LMEs are expected to meet.

North Carolina Department of Health and Human Services

Figure 1 (above) illustrates the Divisions within the Department of Health and Human Services (DHHS) involved in implementing the HCBS waiver, and describes each of their responsibilities.

- DMA delegates approval authority for the waivers to DMH/DD/SAS and the Local Management Entities (LMEs).
- DMH/DD/SAS has primary responsibility for implementing the QM procedures for the waivers at the state level. These responsibilities include:

    - Ensuring compliance with all state and federal audit requirements;
    - Collecting and managing all program and consumer data;
    - Researching and developing evidence based best practice models;
    - Supporting consumer involvement at all levels of the system;
    - Providing training and technical assistance to LMEs

- DMH/DD/SAS and DMA together are responsible for:
    - Oversight of contracts with Local Management Entities (LMEs);
    - Setting performance standards for LMEs;
    - Monitoring regulatory compliance with state, federal, and waiver requirements

CAP-MR/DD Waiver Quality Assurance Activities and Frequency of Activities

Quality Assurance activities begin at the local level with the individual, Consumer and Family Advisory committees, providers, case manager, and the LME. At the state level, activities are completed by the DMH/DD/SAS and DMA in the Department of Health and Human Services (DHHS).

Individuals will:
- Contact their case managers if they have concerns about their services or supports
- Access grievance and complaint processes, with assistance from their case managers, if needed, based on written materials provided by the LME

Individuals and their families are represented at both the state and local level through Consumer and Family Advisory Committees (CFACs). The CFACs:
- Comment on state and local plans and budgets,
- Help identify under-served populations and gaps in the service array,

- Participate in the monitoring of service development and delivery,
- Advise on the development of additional services and new models of service delivery,
- Participate in quality improvement projects at the provider and LME level.

Provider Agencies will:
- Ensure that staff are qualified to deliver services and receive required supervision
- Monitor the provision of services
- Complete Incident Reports as required by DHHS rules
- Complete Death Reports as required by DHHS rules
- Contact the case manager if there are any concerns about the health or safety of the individual receiving services

The Case Manager will:
- Make a minimum of a monthly face-to-face visit with the individual to inquire about any concern or problem with service provision.
- Reassess each individual's needs at least annually and develop a revised person centered Plan of Care based on that reassessment.
- Follow-up and resolve any issues related to the individual's health, safety, or service delivery. Unresolved issues will be brought to the attention of the LME.

Local Management Entities will:
- Provide information to waiver participants about their rights, protections and responsibilities, including the right to change providers. Individuals will also be notified of grievance and complaint resolution processes.
- Resolve issues related to any individual's health, safety or service delivery that are unresolved by the case manager.
- Investigate complaints regarding licensed and unlicensed MH/DD/SAS providers as required by DHHS rules
- Oversee and monitor MH/DD/SAS services provided in the LME catchment area as required by DHHS rules inclusive of provider qualifications
- Receive and review Critical Incident Reports from MH/DD/SAS providers as required by DHHS rules
- Ensure that MH/DD/SAS providers complete death reports as required by DHHS Rules
- Ensure that reporting is made to the County Department of Social Services if the circumstances surrounding an incident, complaint or local monitoring reveal that an individual may be abused, neglected or exploited and in need of protective services
- Complete and submit Quarterly Reports to DMH/DD/SAS, and the local Client Rights Committee to include the following:
- Incidents
- Complaints concerning the provision of public services
- •Complete and submit a report of monthly local monitoring activities to the Division of Facility Services and DMH/DD/SAS that identifies provider monitoring issues requiring correction and an explanation of uncorrected issues.

- Provide on-call emergency back-up through the LME to provide staff in the event that the emergency back-up strategies identified in the person centered Plan of Care cannot be implemented and there is potential that the person's health and welfare would be jeopardized.

The DHHS will complete:

- Monitoring of CAP-MR/DD providers. Monitoring includes yearly audits of paid claims to CAP-MR/DD providers. The sample used in determining the providers to be audited is chosen so as to offer statistical assurance of the overall performance of all CAP-MR/DD providers. In addition, providers with previous records of low performance are routinely included in the sample. The State undertakes reviews of local approval protocols for Plans of Care to assure interrater reliability. When there are out-of-compliance findings for any of these reviews or audits, Plans of Correction are required, and the State follows these plans with reviews to assure correction of system issues which contribute to out of compliance findings. Should corrections not be made, the option of suspension or revocation of a provider's privileges to bill is available.
- Investigations of incidents and complaints that are unresolved at the local level or that have the appearance of conflict of interest with the LME. If there are allegations of abuse, neglect or exploitation, a report will be made to the County Department of Social Services. Incidents and complaints regarding licensed facilities are investigated by or jointly with the Division of Facility Services.
- Track requests for reconsideration and resolutions of requests for reconsideration.
- Review Quarterly Reports of monitoring and incidents submitted by the LME.
- Track and investigate deaths of individuals. Deaths of individuals residing in licensed facilities are reported to the Division of Facility Services. Other deaths are reported to DMH/DD/SAS.

Quality Measures

The following table describes the Quality Framework domains that DMH/DD/SAS is currently using or will use to guide the measurement of system performance, both for CAP-MR/DD waiver and the MH/DD/SAS system.

Domain	Desired Outcome
Participant Access	Individuals have ready access to home and community-based services and supports in their communities.
Person Centered Planning and Service Delivery	Services and supports are planned and effectively implemented in accordance with each participant's unique needs, expressed preferences and decisions concerning his/her life in the community.
Provider Capacity and Capabilities	There are sufficient providers and they possess and demonstrate the capability to effectively serve participants.
Participant Safeguards	Participants are safe and secure in their homes and communities, taking into account their informed and expressed choices.
Participant Rights and Responsibilities	Participants receive support to exercise their rights in accepting personal responsibilities.
Participant Outcomes	Participants achieve desired outcomes.
Participant Satisfaction (with system and processes)	Participants are satisfied with their services.
System Performance	The system supports participants efficiently and effectively and constantly strives to improve quality.

Summary of Quality Management Measures

The following table summarizes the primary QM features according to the CMS regional review protocol components. These five categories are cross-referenced to the relevant HCBS Quality Framework domains. For each regional review category, the table also lists the key measures of performance that are used to ensure quality in each related domain. The table then summarizes how the Quality Management Plan operationalizes the CMS Quality Framework components of **Design**, **Discovery**, and **Remediation**.

The **System Improvement** component is not included in this table. Please note that the System Improvement component will evolve as a key part of the 3-year Quality Management Work Plan described earlier in this document. The Work Plan will develop the structure within which performance measures and other data will be managed to drive continuous system improvement.

CMS Regional Review Protocol Categories	Related HCBS QF Domains	Key Measures	Design	Discovery	Remediation
Level of Care	Participant Access	• Populations served • Timely Access • Notification of denial • Complaints • Service utilization and cost • Penetration rates • "Mystery Shopper"	• Access standards for timeliness • Eligibility criteria • Level of Care determination, and re-determination, standards	• Quarterly report from LME on access outcomes for all new service requests. • Monthly review of eligibility by DMA. • Quarterly monitoring by state Accountability Team. • Annual Medicaid Compliance Audit by DMA.	• Corrective actions required based on report results. • Fair Hearing process for consumers. • Technical assistance from LME
Plan of Care	Person Centered Planning and Service Delivery	• Informed choice about providers • Discharge planning and service coordination	• $ Allocations are based on historical data and prospective cost analyses • Person/Family-centered planning process • Standards for content and structure of plan.	• Case manager oversees and monitors development, implementation, and cost of plan • Contact standards for case managers • LME monitors service costs across all consumers, using Utilization Review Tool • Monthly, quarterly, and annual monitoring reports	• Case manager assures plan changes are made in partnership with consumer/family • LME responsible for consumer satisfaction
Qualified Providers	Provider Capacity and Capabilities	• Use of institutional care • Community service network	• Licensure and Certification (DFS)	• LMEs monitor providers according to performance contract with state.	• LME refers monitoring findings to appropriate state agency for investigation and

CMS Regional Review Protocol Categories	Related HCBS QF Domains	Key Measures	Design	Discovery	Remediation
		profile • Adherence to evidence-based best practices • Provider performance	• Provider criminal record checks • Provider standards (Provider enrollment process)		action • State and LME teams collaborate to analyze monitoring reports to ensure timely and appropriate correction of problems • State provides technical assistance to LME to support oversight.
Health and Welfare	Participant Safeguards	• Critical incidents • Medication management • Restrictive interventions	• Disaster Preparedness, Response, and Recovery plan • Emergency Plans and supplies • Policies on seclusion and restraint • Incident Response System • Complaint and Appeals process • State-level Consumer Services and Consumer Rights (CSCR) team • Client Rights Committees	• Incident response hierarchy assures timely and appropriate processing of incident reports • CSCR team analyzes data on complaints on state level • Client Rights Committees review incidents and complaints at LME level • Mortality reviews by LMEs	• LME uses incident response data to develop monitoring schedules and interventions. • CSCR team reviews all higher level incidents for LME and provider responses
Administrative Authority	• Participant Outcomes • Participant Satisfaction • System Performance	• Clinical outcomes • Personal outcomes • Community inclusion • Criminal justice involvement • Employment and school • Housing • Quality of life indicators • Satisfaction measures for Access, Appropriateness, Respect, Services and supports • Program financial integrity • Information system capabilities • Quality assurance monitoring • Utilization review • Quality improvement process • Participant and stakeholder involvement	• DMA Quality Assurance Program • Quality Management Plan • “Virtual Budget”, data-based allocation process	• Program data collected through MMIS and IPRS • Consumer data collected through CDW, DD-COI, and NCI. • Medicaid Compliance Audits • DMA Program Integrity Reviews	• Reports based on key indicators are shared with LMEs • Providers subject to paybacks and/or plans of correction for compliance audit findings • Program Integrity findings revealing fraud are referred to the Department of Justice.

Quality Management Plan - 1915 (c) Waiver

North Carolina Department of Health and Human Services
Division of Mental Health, Developmental Disabilities and Substance Abuse Services

ATTACHMENT 1

Domain	Desired Outcome	Item	Status	Suggested Reporting Frequency
Participant Access	Individuals have ready access to home and community-based services and supports in their communities.	Services received (units, $)	Currently in use	Q
		Target populations served	Currently in use	Q
		Penetration rates	In development	Q
		Timely access	**In development**	**Q**
Person Centered Planning and Service Delivery	Services and supports are planned and implemented in accordance with each participant's needs, preferences and decisions about his/her life in the community.	**Discharge/after care planning and service coordination**	**Currently in use**	**A**
		Informed choice about providers	**In development**	**A**
Provider Capacity and Capabilities	There are sufficient providers and they possess and demonstrate the capability to effectively serve participants.	**Utilization of state institutional care**	**Currently in use**	**Q**
		Distribution & types of community-based services	**In development**	**Q**
		Provider performance	In development	
		Availability of and fidelity to best practice models	In development	
Participant Safeguards	Participants are safe and secure in their homes and communities, taking into account their informed and expressed choices.	**Critical incidents**	**Currently in use**	**Q**
		Medication management	**Currently in use**	**Q**
		Restrictive interventions	**Currently in use**	**Q**
Participant Rights and Responsibilities	Participants receive support to exercise their rights in accepting personal responsibilities.	**Rights information (service denial notifications)**	**Currently in use**	**A**
		Complaints and appeals (# and types)	**Currently in use**	**Q**
Participant Outcomes	Participants achieve desired outcomes.	Clinical outcomes, improved function	Currently in use	A
		Community inclusion	Currently in use	A
		Criminal justice/Juvenile Justice involvement	Currently in use	A
		Employment/school	Currently in use	A
		Housing (independence and safety)	Currently in use	A
		Personal goals outcomes	Currently in use	A
		Quality of life indicators, well-being	Currently in use	A
Participant Satisfaction (with system and processes)	Participants are satisfied with their services.	Access	Currently in use	A
		Appropriateness	Currently in use	A
		Respect/courtesy	Currently in use	A
		Services and supports	Currently in use	A
System Performance	The system supports participants efficiently and effectively and constantly strives to improve quality.	**Financial integrity**	**Currently in use**	**Q**
		Information systems and monitoring capabilities	**Currently in use**	**Q**
		Quality Assurance process (audits and provider monitoring)	Currently in use	Q
		Utilization Management/Review (high costs, denials or adjustments)	Currently in use	Q
		Quality Improvement process (local)	In development	A
		Participant and stakeholder involvement (CFAC)	**In development**	**Q**
		Quality Improvement process (state)	In development	

Bold items are included in the LME Performance Contract (along with other measures)
Frequency = Q (quarterly), S (semi-annually) or A (annually)

ATTACHMENT 2

System	Purpose	Status for Waiver Participants
Integrated Payment and Reporting System (IPRS)	Service utilization and claims data for state funds. The IPRS will be used to track, pay and report on claims submitted by providers for services rendered. Area programs/LME's will submit a single claim to the state, and the IPRS will process the claim from the appropriate funding source: Medicaid, Pioneer, CTSP and capitated risk contracts.	In use
Medicaid Management Information System (MMIS)	Service utilization and claims data for Medicaid funds	In use
(HEARTS) Healthcare Enterprise Accounts Receivable and Tracking System	Billing system used for state operated facilities. Service utilization and consumer descriptive and outcomes information for state operated facilities	Applies only to individuals in state institutions
Client Data Warehouse (CDW)	Consumer demographics and descriptive information	In use
Decision Support Information System (DSIS)	Integrated consumer data from other data sources	In development
Automated Incident System	Consumer-specific information on deaths, abuse, restrictive interventions, and other incidents	In development
National Core Indicators (NCI)	Consumer outcomes and satisfaction information	In use
Developmental Disabilities Consumer Outcomes Inventory (DD-COI)	Consumer outcomes and satisfaction information	In use (to be replaced by NC TOPPS)
Olmstead Outcomes	Consumer outcomes and satisfaction for Olmstead populations	In use
NC SNAP	Assessment tool for DD populations	In use
NC TOPPS	Web-based consumer outcomes and satisfaction information	In development
MMIS+	Integrated service utilization and claims data for state and Medicaid funds	Planned
Health Information System (HIS)	Integrated DHHS information system	Planned